BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **WILLIAM S. MASLAND, M.D.** Holder of License No. 6352 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-05-0999A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and William S. Masland, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government

regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

5. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

7. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

WILLIAM S. MASLAND, M.D.

DATED: 3/23/06

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 6352 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0999A after receiving a complaint regarding Respondent's care and treatment of a 56 year-old female patient ("P.L.").

4. P.L. presented to Respondent on June 1, 2004 complaining of migratory and deep pain. Respondent noted P.L. was taking 240 mg of methadone a day. Respondent ordered methadone blood levels and imaging studies of P.L.'s back and ordered P.L. to follow up after completion of the tests. Respondent prescribed P.L. a one month supply of 40 mg of methadone to be taken six times daily.

5. P.L. returned to Respondent for a follow up visit on June 15, 2004 complaining of extreme pain and asked Respondent to change her medication from methadone to morphine because methadone was not helping with the pain. Respondent changed the prescription to MS Contin ("morphine") 30 mg eight times daily (240 mg).

6. A medical record should include the medications the patient is taking and the level of the medication in the patient's system, evidence of a physical examination, and the patient's estimated level of pain. Respondent's records did not document P.L.'s methadone levels, that he conducted a physical examination, or her pain level.

7. On June 24, 2004 Respondent reviewed imaging studies and noted P.L. as a possible surgical candidate. Respondent referred P.L. for a surgical consultation, but P.L. was determined to not be a surgical candidate. Respondent did not conduct a physical examination and did not document an evaluation of P.L.'s pain.

8. On August 11, 2004 P.L. followed up with Respondent in his office. Respondent noted a possible diagnosis of fibromyalgia and osteoarthritis, but did not conduct a physical examination or evaluate P.L.'s pain. Respondent increased P.L.'s medication to morphine 30 mg nine times daily ("Morphine #270"). However, Respondent logged the prescription as written on August 2, 2004.

9. On October 7, 2004 P.L. followed up with Respondent in his office. Although Respondent documented a refill of Morphine #270 on this date, it is noted in the record as being prescribed on September 9, 2004. Respondent prescribed immediate release morphine 15 mg quantity 30 for acute flare ups in pain. Respondent noted P.L.'s complaints of gastro intestinal ("GI") pain, but he did not conduct a physical examination and did not chart her pain levels.

10. On December 3, 2004 Respondent refilled P.L.'s prescriptions for immediate release morphine and morphine #270. Respondent logged the prescription as written on November 11, 2004.

11. On February 02, 2005 P.L. followed up with Respondent in the office and again complained of GI pain. P.L. asked Respondent to change her medications from morphine to methadone. Respondent changed the medication from morphine to methadone with a 1:1 ratio (270 mg morphine to 270 mg methadone). Respondent did not conduct a physical examination, document an evaluation of P.L.'s pain, did not order laboratory work and did not schedule a follow up.

12. On February 05, 2005 P.L. was found unresponsive in her home by her spouse. She was transferred to the hospital emergency department ("ED") where she was intubated and revived. ED physician diagnosed P.L. as having respiratory arrest and possible methadone overdose.

13. The standard of care required Respondent, when switching from one long acting opioid to another, to convert the medication by under dosing P.L. by 10-20 %.

14. Respondent deviated from the standard of care because he failed to prescribe methadone in correct conversion dose from morphine to methadone and gave P.L. a quadruple overdose.

15. The standard of care required Respondent to properly and correctly write a prescription for methadone.

16. Respondent deviated from the standard of care because he wrote a prescription for methadone with a 1:1 conversion from morphine.

17. The standard of care required Respondent to order an electrocardiogram (EKG) and lab work for P.L. prior to changing the medication to methadone from a long acting morphine.

18. Respondent deviated from the standard of care because he failed to obtain EKG and lab work prior to changing P.L.'s medications.

19. The standard of care required Respondent to develop a treatment plan for P.L.'s pain management.

20. Respondent deviated from the standard of care because he failed to develop a treatment plan for P.L.

21. P.L. was harmed because Respondent improperly converted a prescription of morphine to methadone resulting in P.L. overdosing on methadone and sustaining a speech impairment and mental trauma.

CONCLUSIONS OF LAW

1 The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2 The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) – ("[f]ailing or refusing to maintain adequate records on a patient.").

3 The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(q) – ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

4 The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(ll) – ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for improper treatment of chronic pain and improper dosing of methadone.

2. This Order is the final disposition of case number MD-05-0999A.

DATED AND EFFECTIVE this 9th day of June, 2006.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 9th day of June, 2006 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 9th day of June, 2006 to:

EXECUTED COPY of the foregoing mailed this 9th day of June, 2006 to:

William S. Masland, M.D.
Address of Record

Lin McGraw
Investigational Review